DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 0 4

2. STATE: COLORADO

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 435.914

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 0.00
b. FFY 2002 $ 0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 2.6-A
Page 24
11.(a) (1), (2)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
Start Date of Eligibility the First of the month

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
As per Governor's letter dated 1994

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Richard C. Allen

14. TITLE:
Director, Health Plans & Medical Services

15. DATE SUBMITTED:
March 27, 2001

16. RETURN TO:
Colorado Department of Health Care Policy and Financing
1575 Sherman Street
Denver, CO 80203-1714

Attn: Deborah Collette
4th Floor

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 29, 2001

18. DATE APPROVED:
4/6/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1/1/01

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
David Selleck

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: Handcarried 3/29/01

FORM HCFA-179 (07-92)

Instructions on Back

Citation	Condition or Requirement

42 CFR 435.914

11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

X Aged, blind, disabled.
X AFDC-related.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

_ Aged, blind, disabled.
___ AFDC-related.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

___ Aged, blind, disabled.
___ AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied..

X Aged, blind, disabled.
X AFDC-related.